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Clear Skin, Clear Path: Transforming Psoriasis Care with Durable Biologic and Oral IL-23 Innovations

Opening:
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Dr. Stein Gold:
Good evening, and welcome. We're thrilled to go ahead and get started. And tonight we're going to talk about *Clear Skin, Clear Path: Transforming Psoriasis Care with Durable Biologic and Oral IL-23 Innovations.*

My name is Linda Stein Gold, and I am a dermatologist, a medical dermatologist from Henry Ford Health in Detroit, Michigan, and I'm thrilled to be joined by two of my friends and colleagues.

Ms. Aldredge:
My name is Lakshi Aldredge. I'm a dermatology nurse practitioner out of Portland, Oregon, and I'm very honored and excited to be here this evening.

Ms. Watch:
And I am Najat Watch, a physician assistant at Henry Ford Health in Detroit, and also very happy to be here in this room. It's going to be an exciting evening.

Dr. Stein Gold:
These are our relevant conflicts of interest.

And let's go through our learning objectives for this evening. We plan to identify appropriate patients who may benefit from earlier initiation of systemic therapy in their treatment course. We're going to evaluate current evidence for durability and dose optimization strategies of IL-23 therapies in moderate-to-severe plaque psoriasis patients, and then we're going to compare the efficacy, safety, and patient preference considerations between the oral IL-23 antagonist and the injectable biologics. Why should we use one versus another in our moderate-to-severe plaque psoriasis patients?

All right. Lakshi is going to kick us off, and she's going to talk about the hidden costs of delay, the impact of delayed biologic initiation in psoriasis.

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Ms. Aldredge:
Thank you so much, Linda. Super excited about this topic, and I feel like this is background that I wish I would have known when I first started out in my career, and I think it's really important background.

So, this was a very exciting study that was just published in March of [2026], so this is hot off the presses, and it's really important data. So, there was a real-world registry data that was greater than 5-year delay. This showed that there was a greater than 5-year delay to initiating biologic therapy in psoriasis patients. So, this is from the British Association of Dermatologists and a Biologic and Immunomodulator Register called BADBIR, and you can Google that to get the reference. It's a fascinating article, and it showed that there were significantly improved clinical outcomes with the initiation of early biologic use. And this can be challenging because a lot of the indications state that they have to have moderate-to-severe disease. And what does that mean? We're going to talk a little bit more about that.

But just looking at our poll, many of you thought that you would initiate treatment earlier than later. We're going to see why that's important. This registry data shows us why it's important. It demonstrated that when you initiated systemic or biologic therapy early, there was faster skin clearance, lower risk of developing comorbidities, and improved clinical outcomes. Just those three things translate into one of the most important thing, which is why we're all doing what we do, improving the quality of life for our patients, and very specifically our psoriasis patients.

So that, in and of itself, those three points should hopefully make you really start thinking about what early initiation of systemic therapy means.

So, this was a study of over 3,700 patients with moderate-to-severe psoriasis, with a PASI of 10 or greater, since 2007. And what it did was it compared a first-line initiation of biologic therapy versus conventional therapies, and that includes methotrexate, cyclosporine, acitretin. 3,300 or so received the standard of care, and about 334 received biologics as first-line therapy.

And what they looked at was the PASI change over 5 years, so this was a long study. And what they looked at was the secondary outcomes of time to being completely clear, or a PASI score of 0, the change in their quality of life using the DLQI, which we know is a validated tool that patients complete, talking about various aspects of their life that their disease may impact, and then it looked at the first diagnosis, the time to the first diagnosis of any of those comorbidities that we think about that are associated with psoriasis, which we now is know is a huge, long list.

So, the characteristics of these patients were interesting. These were older patients, they tended to have more comorbidities, they were more likely to have also concomitant psoriatic arthritis or joint disease, they had a longer disease duration having psoriasis, and they tended to have higher PASI scores. So, in the real world that we all practice in, this is a lot of our patients. They come to us already having significant disease burden, having comorbidities, hypertension, cardiovascular disease, metabolic disease, and they tend to have had longer disease duration. And in past studies, we have seen that patients tend to have disease for about 8 years before they finally get on a treatment that is truly effective and impactful.

So, what they looked at was the outcomes in patients that received biologic therapy. They had a lower PASI at 1 and 5 years, lower DLQI at 1 and 5 years, and lower risk of developing new chronic comorbidities over 5 years. They also looked at PASI 0, which is absolutely no psoriasis anywhere, not behind the ear, not in the fingernail base, not in the upper gluteal crack. So, all of the places that wou- like 0. That is an incredibly high bar to meet. In biologic-initiated patients, the patients that met that bar: 58%, and the time to clearance was 13.3 months.

Look at those who had conventional systemic therapy initiated: 32% of those patients met that high bar, and I actually think that that's pretty surprising, given that the only thing that we've seen of those three is cyclosporine, and you can't be on cyclosporine for a long term, as we all know. But look at the time to clearance: 23.3 months to reach that high bar.

So, thankfully, and I hope- hopefully we're not still using a lot of these conventional therapies all that often, but this was great data, great registry, robust data that really advocates for us to initiate biologic therapy or biologic-similar therapy sooner than later for no other reason than we can improve their quality of life, we can clear their skin, we can prevent early onset of those comorbidities, or perhaps prevent them altogether, and then, of course, get them living life again.

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Okay. So, we know that psoriasis is much more than skin deep. When I first started out in this world of psoriasis 25 years ago, this list was probably two. We knew that there was joint involvement, and perhaps there was an inkling that there could be cardiovascular comorbidities. Look at this list now, and it's still growing. So, there's, besides the psoriatic arthritis, cardiovascular disease, everything that falls under metabolic disease, inflammatory bowel disease. And you guys, this is a big one; this is something we really need to start paying attention to: malignancies, chronic kidney disease. Who would have ever thought sleep apnea or GERD was associated as a comorbidity? But now COPD, uveitis, and we're going to start seeing more inflammatory eye conditions associated, and now what we used to call NASH is now metabolic-associated liver disease.

So, these are all huge, impactful comorbidities that completely affect patients, their families, their ability to make a living, but more importantly, their ability to enjoy life. And we have the ability to potentially prevent or alter the course of these comorbidities in our patients.

If we think about just the psychological impact of psoriasis, we used to think back in the day that, of course, people are going to have increased depression, anxiety if they have psoriasis. This is a very visible disease, unlike diabetes or hypertension. Your neighbor doesn't know that you have that by looking at you. Our psoriasis patients suffer with this. It's very visible. Of course, it's going to have a psychological impact.

But what I will challenge you to think about is the inflammation that is happening in the skin, in the gut, in the liver, in the heart, is also pathologically happening in the brain. So, it's not just you feel really bad because everybody can see your skin; there's actually pathology that's happening in the brain, and we have the ability to significantly impact that. Okay?

We know that patients are also at higher risk for suicidal ideation because of this, so it's important to keep that in mind. Patients may not readily give that up, and unless you're asking about how does this impact your day-to-day living? How does this impact your relationships? How does your disease bring joy into your life or keep you from living a joyful life? That is a question I ask every single one of my psoriasis patients every single visit, and it's impactful. Okay? So I think this is really important background information for us to have.

So, think about all of the things that when we think about quality of life, think about what you and I do for a living, what brings us joy. Lifestyle choices can have a huge impact on what other diseases we have, diet, exercising. We know our patients with psoriasis and more severe psoriasis have a higher incidence of smoking and alcohol abuse. We know that our patients, it significantly impacts their ability to work or be productive or effective in school. We have more missed days of school.

We know our psoriasis patients lose their jobs more often than the general population. There's decreased work productivity and functionality, and what that translates is they lose their jobs and they lose their financial stability. This can be hugely impactful. I have had patients who have lost their homes because they're not able to keep their jobs. And when you think about the comorbidities of psoriatic arthritis, patients who are machinists, electricians, you know work in food industry, these people struggle to have and maintain their jobs. And when it's your livelihood, it adds to that emotional and psychological distress.

These patients also have significant difficulties maintaining and engaging in social relationships. I had a patient who was 35 who had never ever dated because they were so afraid that, 'Who would want to be with me with my skin looking like this?' Thirty-five years of age, from high school, grade school, never had gone to a dance, never had ever asked anybody out on a date. Hugely impactful. The fear of stigmatization, social withdrawal, sexual dysfunction. These patients are not living a beautiful, joyful life because of the disease. That is something that we can impact and must impact.

So, the National Psoriasis Foundation, which is a beautiful organization that was actually started in my hometown of Portland, Oregon, with a psoriasis patient, a young psoriasis patient, a young woman, 35 years of age. Her husband put out an ad in the paper that said, 'If you have psoriasis, please come meet my wife,' and that is how they started as a small chapter in their home, now an international organization. So, the National Psoriasis Foundation set, and also now in consideration with the International Psoriasis Council, partnered together, set these target goals: 1% body surface area within 3 months of starting a new treatment.

We need to bring our patients back in 3 months, if not sooner, to see if that new therapy that we have initiated has at least reduced their skin burden down to 1% BSA. An acceptable goal is 3% BSA, or 75% improvement in their baseline BSA after 3 months. But after 3 months, in this day and age, if they're not significantly improved, you need to be thinking about whether that's the right choice for the

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patient or you have it at the right dose. Alternative targets include an achievement of a Physician Global Assessment, PGA, score of 0 or 1, which translates to clear or almost clear, or a PASI 75% improvement from baseline or 90% improvement from baseline.

Monitoring at least every 6 months when you first start seeing that patient and see how they're tolerating treatment, see if they're seeing your expected improvement, and that you're not just scheduling a 1-year follow-up and hoping for the best.

So, again, this is the joint statement that just came out from the International Psoriasis Council and the National Psoriasis Foundation. 2020 classification for topical therapy was mild to moderate. So we always graded severity of disease by body surface area: 0 to 3 was mild, 3 to 9 was moderate, and greater than 10 was severe. Now we're challenged by either, is this patient a candidate for topical treatment, or is this patient a candidate for systemic therapy?

So, if they're a candidate for systemic therapy, the guidelines say they must meet one of these three criteria: a BSA of more than 10%, involvement in a high-impact site. Those high-impact sites include the scalp, the genitals, the palms, the soles, and even the nails. Or the failure of topical treatment. What does that mean? They actually went on to define what failure of topical treatment is, and that is the inability to reach clear or nearly clear skin after two consecutive 4-week courses of a topical treatment. So, I don't know what patient has actually been able to do this, but 4 weeks of consecutive treatment with topical treatments every day, sometimes twice a day, two of those 4-week courses. If they're not able to achieve clear or near-clear skin, they are a candidate for systemic therapy.

So, look at this. This is a really fascinating chart, and this looks at all of our biologic therapy options currently and their onset of disease. The pink bar represents those that are able to achieve PASI 90. The blue bar are the PASI 75 data. And you can see that those IL-17s, the bar at the bottom is weeks, okay? Not days, but weeks. So, you can see IL-17s have really been able to kind of take the lead as far as faster onset. Brodalumab is at the top of the bar, bimekizumab, ixekizumab, secukinumab. They've really kind of ramped up the game as far as early onset of achieving PASI 90 and PASI 75.

Back in the day, we were excited with PASI 50 and PASI 75 when we had the very early TNF-alpha inhibitors. Thank goodness now that we have these agents, because none of our patients—when we ask our patients, NPF polled our patients, said, what are your four priorities? They want something that is quick to work, that is durable, that is in it for the long haul, and that is safe, and that is easy to use. Those are the four priorities our patients stated.

So, if you look at this, methotrexate is not going to meet that bar. Okay? That is just not going to meet that bar for fast onset. Our TNF-alpha inhibitors, great drugs, we were happy to have them, but it's nice now that we can have other agents that really produce that faster onset to meet that need for our patients.

What about durability? That was a second priority for our patients. So, this is a representative table that shows the durability comparison across the biologics for plaque psoriasis, and you can see that there's representative drugs in the 23 focusing on p19, targeting IL-17, and then our one IL-12/23 agent. Durability long term. You can see that the IL-23 has some of the highest bars when it comes to durability, 4-year survival of greater than 90% when we talk about risankizumab. But look at the IL-17, still high. A superior rapid efficacy, ixekizumab compared to IL-23. So, in that category with ixe, we actually have durability along with faster onset of clearance. And then the IL-12/23, moderate, with lower than IL-17 and IL-23.

The time to max response. The IL-23s were again a little bit slower than our IL-17s, which are fast. I showed you that in the slide previously, 2 to 4 weeks.

The IL-12/23, moderate.

And then the dosing frequency. For our 23s, we have some nice longer, for patients who don't want to take an injection very often, every 8 to 12 weeks. For our 17 inhibitors, it's usually every 4 weeks, and then for our IL-12/23, again also every 12 weeks.

And this is a nice odds ratio graph, and basically what this is showing you is another view of that durability. So, I'm not going to belabor the point. The point is that the closer that you get to the middle dotted line, the closer that you are not favoring an IL-17. So, this is really looking at the durability and comparison of these agents favoring versus an IL-17, and what this is showing is is, as you can see, the TNF-alpha inhibitors are moving away from that. IL-23s also are coming closer to the bar. So, IL-17s really seem to have a good place as far as speed of onset, durability.

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But what about safety? That's the other- the third priority that our patients mentioned. So, when we look at the IL-17s, the most common adverse events that we saw were nasopharyngitis, upper respiratory tract infections, injection-site reactions, candidal infections. And that's something that we need to keep in mind, because we also want to be cautious in using these agents in our patients with a known history of IBD.

IL-23, risankizumab, guselkumab, tildrakizumab, again, very similar safety profiles for common adverse events: nasopharyngitis, headaches, fatigue, upper respiratory tract infections, but it didn't have that tinea or Candida signal. Highly favorable safety profile, lower risk of long-term side effects, and again, no contraindication in our patients who might have bowel or IBD-type symptoms.

And then finally for ustekinumab, very similar to the 23s, and generally safe, very long track record. Of all of these listed, it has the longest profile.

So, let's put this into practice. I went through the data, we looked at the BADBIR registry, but now let's take it real world. When you go back to work on Monday, we have Maria. She's 34 years old. She was diagnosed 5 months ago with plaque psoriasis in her arms and in her genital area. She has well-controlled hypertension. Her BSA is about 7%, but sleep, intimacy, and work performance are suffering. They've cycled through multiple topicals on and off without clear resolution, and they say, 'I struggle, but am I actually sick enough for systemic therapy?' she asks you.

Dr. Stein Gold:
You know Lakshi, you talked about the IPC. This is so important, and you really emphasized the fact that we don't do a good enough job. We don't do a good enough job to get our patients to systemic therapy, and so when we think about the case that you just presented, what would push you towards systemic therapy?

Ms. Aldredge:
Yeah, the fact that Maria has genital involvement, remember the IPC criteria said high-impact sites. That is one of the criteria that is met. But also the fact that her quality of life, she's not engaging in relationships, her work is suffering, so just the high-impact site meets that criteria.

Dr. Stein Gold:
And Najat, thoughts on this?

Ms. Watch:
Yeah, also the fact that she has cycled through so many topicals. So even though we have obviously in our landscape right now other topicals that are non-steroidal, I think this is a patient who said, 'Oh, another cream. You're going to give me another cream.' Right? So we may lose that patient. They might not return, so we have to think of what- how can we do better? And again, at this point, there's burden, there's possible job loss, intimacy issues, so we have to move forward and do better for her.

Dr. Stein Gold:
So do each of you think, say somebody only has 1%—and remember, 1% means the patient's hand, like this—if they have 1% body surface area, but it happens to be in the genital region, is that reason enough to start a systemic?

Ms. Aldredge:
Absolutely. If there's not a topical, or several topicals that have been tried, and patients report that that's a sensitive area to apply topical agents.

Dr. Stein Gold:
It's humiliating. It's absolutely humiliating. It's itchy. It's not appropriate to be scratching that area in public. It's not appropriate to just be scratching any area in public. Absolutely, it is okay to start a systemic agent.

There are a number of reasons for her failure to respond to topical therapy, and the fact that the IPC has defined that two 4-week trials, that's every one of our patients, so we do not have to continue to cycle through topical therapy.

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Dr. Stein Gold:
We're going to move on now, and Najat is going to come up, and she's going to take us through the second section of *Durability Matters: Optimizing Long-Term IL-23 Response.*

Ms. Watch:
So, again, I know that we've already mentioned that the landscape has changed quite a bit, and you know having been in practice you know getting close to 20 years, how we started things with psoriasis. We had not too many options, right? And I think our suggestion to our patients, they weren't great. We'll try to get you a little better. Well, that has changed, and so I think when we think about the durability, we have to think, how are we going to get them clear? So that is what I say to my patients now. Being a little better, it is not good enough, because the burden is quite great. This impacts all aspects of patients' lives.

So, the great thing about the durability is now we can say our goal—and I think we have to commit to that—is saying our goal is clear. And I think how we get there, and we'll talk about how that sort of transition will be made, we have to think we're going to be aggressive early. We're not going to let things get out of hand. We don't want to just say, 'Here's a topical. Come back in 6 months, and cycle and cycle. So, if they're not better in a short time, whether it's 2 or 3 months, we move on to something else.

And so we went over this a little bit in similar nature, but again, how do we get those patients there? We're not prescribing—at least I'm not anymore—things that are not going to be quite effective. No one wants to wait 2 years to be a little better. And so when we're thinking about the landscape, we're thinking, okay, 17s and 23s. These are the ones we're going to yearn for. Now, depending on the patient—we'll talk about that in a minute—we'll pick appropriately depending on comorbidities, depending on travel, things like this.

But again, the goal is to be clear. And so we see if someone needs to be clear for an event, if they're in extreme pain, we're going to lean on some of the 17s for that real quick action. But for the long haul, I really think that the 23s really, you know they are the ones that are winning the race still. And we have now other options besides obviously injectable, but again, we have to think we're not going to give someone a treatment that's going to make them a little better. Those patients want to be clear, and that should be our goal as well.

And again, as we've said, this landscape has changed dramatically. We had you know medications where we'd have to say this is immunosuppressive. We're checking lab work. You may not even improve. You may have you know toxicity. We might have concern about other things that we're causing, and their skin might not even be that much better. So our goal here for our therapies is to think, okay, in the long haul, right? When we're looking at a year or maybe even 2 years, how are we going to get them to be clear, stay clear, but then also have that safety profile, picking something that someone says, 'I feel comfortable staying on this for a long time.'

And so when we're thinking about this landscape, the 17 versus the 23, as we see for the long haul, to me the 23s, they win, right? We see many clinical trials that you know comparing and contrasting, but when we see the 23s compared to 17, this one with the guselkumab, with the secukinumab, we say, well, you know yes, the one leads out of the gate, but for the long haul, the 23s are really you know what we're going to lean on. And so I think as far as not only efficacy but the safety profile, these should be the drugs that we think of.

And so I think we all have to do better in screening new patients. We had a conversation just yesterday. How many patients come in and say, 'I don't have a PCP. I don't know the last time I had lab work. Can you be my family doctor too? I really like it here,' and I usually say no, I prefer not to. But really, we're seeing them regularly, and often we're doing some screening labs, and we find some very interesting things. Sometimes you know we're ending up sending to hematology. I have patients I've diagnosed with leukemia in their initial presentation, saying, well, we're not going to go to that quite yet. Let's get these other things under control. Undiagnosed hepatitis, TB untreated. And so we want to make sure the patient's healthy. But again, struggling if they've got inflammatory bowel disease, right? We're going to lean to the 23s. If someone has had, again, a history—candidiasis is no joke. It is awful. Those patients will hate you forever if you end up worsening something that's already established there. And so it's an awful condition, and very difficult when you put patients on 17s. So, there are definitely things.

Now, as far as arthritis, we have a wonderful rheumatology-dermatology group, and those are great situations where the rheumatologist can kind of explain, 'okay, they've got axial involvement. Oh, they have, you know again more peripheral disease.' That will guide us sometimes towards what biologic is best.

Again, I'm going to say this probably three times. Our goal is clear. Our goal is no itch, and it's wonderful in 2026 that that can be our

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goal, and I think it should be.

And as APPs especially, I feel very fortunate that I can say to my patient, my goal is to get you clear. You're not going to come back and say, 'I'm a little better, my itch is a little better,' and then I look at them and they're really not improved.

The bar has been so low for inflammatory skin disease for so long that patients will say, 'I'm better,' and they're like trying to convince themselves, and you look at them and say you're not. And in these high-impact areas, right, where they can't do their job, they're a nurse, they can't work because their hands are broken out and they're bleeding, they're covering up, they're not intimate, they say, 'I haven't you know had any relationship in years because I'm bleeding in the genital area,' hard to keep clean, secondary infection. So we have to say our goal is clear. It's gone, and we move quicker than maybe we would have in the previous years.

And so this is kind of a nice segue. We have this landscape, right? IL-17, 23. Now what do we have next? And I think Dr. Stein Gold will go through that.

Dr. Stein Gold:
Thanks, Najat. These have been really interesting background talks, where we hear about where are we, what do we have. And we have some absolutely amazing options. We have biologic drugs that can get our patients clear, they can get our patients clear fast, and they can keep them clear.

One of the problems is when we have that conversation with our patients, when we have a patient that we've identified that needs systemic therapy, we have not necessarily had an oral agent that has the triad of great efficacy, great safety, and great tolerability. So, what happens is when we have the conversation, we don't always offer an oral. We might offer an oral, but maybe it's not giving us what you guys have just mentioned, getting us to that high bar that we never dreamed we would reach for in the past.

So why should we even offer an oral? Who cares? Well, you know what, we haven't been asking our patients what they want. And when you actually ask a patient, or even ask a healthcare provider, would you prefer to use an oral agent, a topical agent, or an injectable agent? If you take the time to ask them, many times what we will hear is, 'If you can give me a pill that offers me the efficacy, the safety, and the tolerability that I need, I think I'd like to try a pill.'

Some people prefer a shot that they don't have to think about anymore, but that comes with baggage as well. It has to be refrigerated. You can't just walk out of the house with it. You have to think about it when you travel.

And when we look at patients by disease severity, if you have localized mild disease, low BSA, a lot of people don't mind using a topical. But if you have moderate-to-severe disease, at least in this study, patients wish you would offer them an oral agent.

When we think about systemic therapy, we can put them into little buckets. We have small molecules. Apremilast and JAKs are small molecules. They can be taken easily by mouth. That's easy. They have high oral bioavailability. We don't worry about taking a pill. But what's wrong? They're not highly selective. Who cares? If you're not highly selective, you'll have an off-target impact, and that means you can have side effects. You can have drug-drug interactions.

On the other end, we have the monoclonal antibodies, the biologic drugs. These drugs are highly selective, highly potent, highly specific. They will zoom in on an exact protein. But what's the problem? Well, you can't take this huge molecule by mouth. You've got to take it by a shot.

Now we have a middle category that we haven't had in medical dermatology before. We have the oral peptides. And why do I care about an oral peptide?

Because this is now highly selective, they're highly potent, they don't have off-target effects. We don't see drug-drug interactions. The problem is they can be difficult to take by mouth. We can't get them absorbed really, really easily.

We have a new oral agent called icotrokinra. What's unique about this is it's an oral peptide, and it targets not IL-23 but the IL-23 receptor. And this drug is so potent that even though a small amount is absorbed into the system, it works with an efficacy similar to a biologic agent.

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This is a head-to-head study, and this drug was recently FDA approved all the way down to age 12, so adolescents out of the gate. We have four phase 3 clinical trials that were done even before the drug got FDA approved. And when we look at this drug, active drug versus the placebo, we see this pill kicks in fast, and we see high efficacy. The primary endpoint was at week 16, but it continues to improve, and we're getting patients high levels of clearance.

They did a study in special sites. You talked about the importance of special sites. What's unique about this study was you only had to have 1% body surface area, but it had to be in a high-impact area: the scalp, the palms, the soles, the genital area. And we saw when we have that high bar of getting completely clear, one pill once a day got almost 1/2 these patients clear, completely clear of their scalp disease, and 62% completely clear of their genital disease by just week 16.

This is an interesting study, and I kind of take pride in this study, because this study was published in *The Lancet*, and this is a head-to-head study of icotrokinra versus deucravacitinib versus placebo. Henry Ford Health System every year has a competition, and they look at all the publications that came out of Henry Ford Health System, and they pick the very best publication of the year. Guess what? The very best publication of the year was, as of last month, it was this study. So I- Henry Ford, which is not- you know, they have a great derm department, but this was all the departments, and they found that this was the most impactful study of the year, because this study showed that ico was statistically superior, not only to the placebo, but also to the active deucra, which is a TYK2 inhibitor, and we saw more rapid onset of action and more complete onset of action with one pill once a day.

Safety. We are safety first. I am the most conservative dermatologist you are ever going to meet. I am so concerned about that I do no wrong. And when we look at the side effect profile, we found that, in fact, the infection rate was comparable to placebo. The serious adverse reaction rate was comparable to placebo and less than that of deucravacitinib.

And I want to make one comment, one final thing. If you look at the package label for the IL-17s and the IL-23s, it is mandated by the label that you do a TB test. We don't think it's warranted. We don't think by the mechanism of action that that's important. It is important for the TNF inhibitors, but it's really not- mechanistically, it doesn't make a lot of sense for the 23s and the 17s. If you look at the PI for ico, that mandate is not there anymore. It basically states that it is recommended that you use your judgment, and you can either test or not test. But you should know that in the clinical trials, there were 30 patients who tested positive for TB that did not have signs and symptoms. They were not treated for TB, they were treated with icotrokinra, and did not develop any signs or symptoms of TB. So, you can have some reassurance that if you want to start somebody without any blood work or lab monitoring, that's fine.

So, we're going to go into our next case. We're going to talk about Justin. He has moderate plaque psoriasis. It's not under control. Five-year history. He's got 12%, so technically by all accounts he is a candidate for systemic therapy. He has scalp involvement. He's itchy. He's not sleeping. He cycled through topicals. He thought about phototherapy. He travels a lot, and even though injections are not that frequent, you still have to plan it. 'What if I'm going to be out of town for 3 weeks and my injection comes then? I don't want to go through TSA security with a cold pack and my shot.' So he prefers a pill.

Dr. Stein Gold:
So, thinking about this, I want to ask you both, and I want you to be honest. Do you normally offer an oral?

Ms. Aldredge:
You know I'll tell you very honestly, I had to retrain my brain to go back there, because for so long it has been when I see those patients who are candidates for systemics, I have been trained to think about biologics as the next step. Now that we are having these new molecules that are oral, offer a different level of maybe comfort for some patients, because I literally do have patients who come in every 3 months for me to give them their shot, or my nurse, because they absolutely will not. This is just a lovely option to have an oral option and we're going to see others come down the line that offer the efficacy of a biologic with the ease of an oral agent.

Dr. Stein Gold:
What about you? Do you have that conversation? Or you don't care, you give them what you want to give them?

Ms. Watch:
No, I'll give a quick example. I've had a few now failures of 23 and you know and so I kind of go back to the drawing board, because they're not doing well, and it's often with all of them, it's been these high-impact areas, a couple of them with hand—palmar—and nails,

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which I find the trickiest. I can have someone who's got you know BSA 15%. Their plaques are gone. Their nails are the same or worse, and they're not happy because if they work with their hands, if their nails are crumbling and they're painful, they want something else. So it's not good enough, and so I think as we dig deeper, and like I was saying, when clear, almost clear, they want to be clear, 100%. So I think we have to think about these other options.

Dr. Stein Gold:
Yeah, I do, and I'm going to tell you there is still a need for biologic drugs. The oral agents are an amazing option, and they will function at the level of a biologic, but we still are going to need the biologic drugs. Maybe not everybody responds to an oral agent. Maybe that's going to be your first step after topicals, but we still need the biologic drugs, especially the 17s, and even you know an oral 23 is not the same as the biologic 23. I can see even transitioning from one to the next or to a 17 drug, but I think these drugs are really important, and we see the reasons here why people would recommend an oral 23: preference, convenience. Absolutely.

Dr. Stein Gold:
I want to thank everybody. I know it's a long day, and we're into the evening. Hopefully, you enjoyed a glass of wine and some cheese and crackers. Can you give us some closing thoughts? What do you hope that people take away and bring back to their office? Najat, let's start with you.

Ms. Watch:
Yeah, I often will say to my patients, and I precept a lot of students, and I say there's never been a better time to treat psoriasis, and I truly believe that, having done this for a long time, and I used to say, 'Well, we'll try to make it a little better, and so we can make a very big impact on these patients' lives. And again, if our goal is to get them clear, that's what we would want for our own bodies. We make that same commitment to them and say that's where we're going to get you. Sometimes the road is bumpy, but I think we have to pivot quicker. I think that's my overarching—don't be afraid to pivot. Don't say it's okay, and we're going to give up. And if patients really feel that you are the one who is going to guide that, they will be forever loyal.

Ms. Aldredge:
I think I would say, look at these. Don't just take our word for it. Use your MSLs, your sales reps that comes in, visits you. Look at this BADBIR Registry data. Look at the evidence that we're sharing with you. It is incredibly powerful that you have this knowledge. The fact that you guys took the time to sit here this evening after a very long day shows us how committed you guys are to your psoriasis patients, and that is huge.

But look at these. Look at this evidence. Look at the guidelines from the National Psoriasis Foundation and IPC, and keep that in mind. The people on these boards are brilliant, and they look at the evidence that all of the companies who create these wonderful molecules, all of the clinical research, and the thousands of patients that participate in these clinical studies, the wonderful data that we have now, the evidence that we have to reassure our patients that systemic therapy is really our goal for those patients who qualify for it. We've lowered the bar for those patients who do qualify for systemics, and we owe it to them to give them that opportunity to live a quality life.

Dr. Stein Gold:
Thank you for that. And I would just conclude by saying there is a cost of not treating. If I had moderate-to-severe plaque psoriasis, and I was not offered the opportunity to go on a systemic agent that might change the trajectory of my disease, that might change the comorbidities that are associated with it. We can't tell you 100% that you're not going to die of a heart attack because we now got your psoriasis under control, but I can tell you that you are at higher risk of dying with a heart attack if you have moderate-to-severe psoriasis than if you have no psoriasis or mild disease.

So, when you say to a patient you have systemic inflammation, you have comorbidities, I think it's important. And we have data that now shows us the better controlled you are, there is data to suggest that you might not progress to some of these comorbidities. I think it's imperative to do the best that we can.

So, thank you so much for listening. Thank you for attending.

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